Government of Northwest Territories
Gouvernement des Territoires du Nord-Ouest

PROVIDER FORM – *Northwest Territories Mental Health Act*

COMMUNITY TREATMENT PLAN – CONSENT OF PROVIDER

* The Attending or Supervising Medical Practitioner preparing or amending the *Community Treatment Plan* **must** ensure that a signed *Community Treatment Plan – Patient Consent* has been completed before contacting a provider to perform supervision, treatment, care, and/or support under a *Community Treatment Plan*. Providers can be health professionals, persons, and/or bodies.

Name of Patient		Gender
Health Care Number		Date of Birth (DD-MM-YYYY)
Address of Patient		
Street	Community	Postal Code
Designated Facility (where admitted)		
Name		
Street	Community	Postal Code
Medical Practitioner Preparing or Amending *Community Treatment Plan*		
Name		
Street	Community	Postal Code
Email Address	Contact Number	
If Different, Medical Practitioner Responsible for General Supervision and Management of *Community Treatment Plan* (Supervising Medical Practitioner)		
Name		
Street	Community	Postal Code
Email Address	Contact Number	

Current Involuntary Admission Certificate	**Date of Issue (DD-MM-YYYY)**	**Time of Issue**	**Name of Attending Medical Practitioner who Issued Certificate**	**Date of Expiry (DD-MM-YYYY)**	**Time of Expiry**
Certificate of Involuntary Admission					
OR *Renewal Certificate*					

Supervision, Treatment, Care, and/or Support Arrangements

The following outlines the roles and obligations of the provider who has agreed to supervise, treat, care, and/or support the patient under the *Community Treatment Plan* (or *Community Treatment Plan, Amendment*) and report to the Supervising Medical Practitioner.
**Attach additional page if more space is required.*

Name of Provider		Telephone
Street	Community	Postal Code
Other Contact Information		

☐ Appointments ☐ Home visits ☐ Telephone contact ☐ Telehealth ☐ Other (specify): _____

Profession/Role

Description of treatment or care:

Location (if applicable) **subject to change based on clinical need*	Frequency (if applicable) **subject to change based on clinical need*

Information to be drawn to the attention of the provider by the medical practitioner (if any):

PROVIDER AGREEMENT

To be Completed by Provider

I, _____, have read and understand this *Community Treatment Plan – Consent of Provider* and agree to the performance of my roles and obligations in the *Community Treatment Plan* as set out herein to the best of my ability. I consent to my name and participation in the *Community Treatment Plan* being shared with other participants. **I will not use or disclose personal health information of the patient for any purpose other than the performance of my roles and obligations in the *Community Treatment Plan* or to carry out a legal duty.**

_____ X _____
Printed Name of Provider Signature

Dated this _____ day of _____, 20 _____ at _____ .
(Time)

Medical Practitioner Preparing or Amending *Community Treatment Plan*

_____ X _____ PLEASE PRINT FORM TO SIGN
Printed Name of Medical Practitioner Signature

Dated this _____ day of _____, 20 _____ at _____ .
(Time)

Additional Actions Required:

- Medical practitioner must append to *Community Treatment Plan* or (if applicable) *Community Treatment Plan, Amendment*.

The personal health information on this form is being collected under the authority of the *Mental Health Act*. It is protected by the privacy provisions under the *Health Information Act* (HIA) and will not be used or disclosed unless allowed or required by the HIA or any other Act. If you have any questions about this form, please contact the Clinical Mental Health Program Specialist at 867-767-9061 or mhact_reviewboard@gov.nt.ca